



OWITS Billing Module

User Guide

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OWITS Billing Module

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Agency Setup

Agencies using the billing module and 837 file generation feature in OWITS must ensure the following fields are populated. Use the information below to check your Agency Profile.

From the Navigation view go to:

Agency > Agency Profile. In the Agency Profile, check the following:

1 National provider ID is required and must be valid.

2 Federal Tax ID is required (all billing types).

3 Go to the bottom of [the Agency Profile](#) screen and click the right arrow button. This takes you to the “Addresses” Screen.

Agency Profile

Agency Name: Administrative Agency
Display Name: Test Agency #1
Start Date:
Govt Organization:
Parent Agency:

DBA: State of Oregon
Agency Type: Substance Abuse Treatment
Inactive Date:
Consumer Rep Met:
URL:

Agency Features: Care Coordination, Recovery Support, Service Provider
Selected Agency Features: Funding Reporting, Contract Management

Contract Role: Provider
National Provider ID: 1111111111
Federal Tax ID: 12-1231231
State Business ID: 123123
Contractor/Locator:
County: Marion
Tribe:

Agency Faith Based: No

Treatment Domains: ATR
Selected Treatment Domains: Substance Abuse, Mental Health

Comments:
Pseudo Agency: No
Senate Dist:
House Dist:
Cong Dist:

Buttons: Cancel, Save, Finish, Search

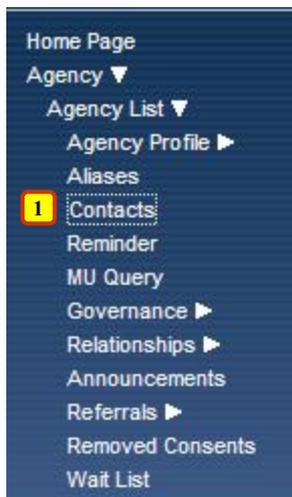
Agency Billing Address

1 Agencies must have a valid **Agency Billing** Address type and phone number. 837 file will generate an error if the **Agency Billing** address is missing. A PO Box does not currently work for a billing address. OWITS support has a workaround.

2 The Agency Billing address must have a 10 digit phone number. Do not add an extension. (example:(555)555-1234)

Addresses Add Address				
Address Type	Address	Phone	Updated	Actions
Agency Administration Office	500 Summer St Salem, OR 97303		12/9/2010	Review Delete
1 Agency Billing	500 Summer Street Salem, OR 97301-1118	2 Billing / Accounting (888) 555-5555	8/28/2012	Review Delete
Agency Treatment Location 2	500 Summer St NE E86 Salem, OR 97301		7/2/2012	Review Delete
Agency Mailing	PO Box 9421 Troutdale, OR 12345	Work (888) 888-8888	7/2/2012	Review Delete

Agency EDI Contact



1 From the Navigation View, go to *Agency > Contacts*. (Staff account must exist before this step).

2 Each Agency must have only one Agency Contact with a contact type of **Agency EDI Contact**.

The contact is usually the billing staff member. Entering more than one EDI contact causes a file generation error. If you need to change/add the Agency EDI contact either:

3 **Inactivate the contact:** In the [Actions](#) column select [Review](#) next to the contact name or **Add Contact**.

Contacts for Administrative Agency					
Contact Type	Name	Status	Created	Effective	Actions
Fiscal and Contract Administration	Anderson, Sharon	Active	2/9/2011	2/9/2011	Review
2 Agency EDI Contact	Huber, Michael, LCSW	Active	4/23/2012	1/1/2010	Review 3
Agency Billing Contact	Garifalos, Nik	Active	4/23/2012	1/1/2010	Review
Contact Person	Garifalos, Nik	Active	4/23/2012	1/1/2010	Review

4 The Agency EDI Contact account edit/add contact window will open. From the **Status** drop down menu, select **Inactive**.

5 **Add Contact:** Click on the [Add Contact](#) link. Select the Staff member from the drop down menu and select the Agency EDI Contact from the **Contact Type**. Select **Status** of **Active**. The Effective date is required even though it is not yellow.

5 [Add Contact](#)

Staff

Contact Type

Effective Date

Status **4**

Manager Name

Agency Contact Staff Account

The EDI Contact staff account can be accessed, edited or added by doing the following:

- 1 From the Navigation View go to *Agency>Staff List>Staff Profile* and search for the staff name or create a new staff record..
- 2 The staff profile must have a valid email address.
- 3 The start date should be the staff employment date.

1 Staff Profile

First Name	Chelsea	Middle		Last	Clinton
Prof. Credentials		Gender	M-Male	DOB	

Taxonomy

Category	
Sub-Category	
Specialty	

2 Email	chelsea.clinton@state.or.us	Staff Type	State Staff
Social Security		Clinical Supervisor	
National Provider ID	1447567755	Manager Name	Mikan, Leslie
Title		Employment Type	
3 Start Date	6/27/2011	End Date	
Dev Plan Date		Perf Rev	
Last TB Test Date		Comments	
Policies & Procedures Manual Reviewed?		Background Check Outcomes Acceptable?	
Required Background Checks Completed?		Last Performance Appraisal Process Participation?	

ber_training 5/30/2012 3:47 PM Cancel Save Finish

Agency Contact Staff Account

continued

1 In the staff Contact Info, the staff account must contain a **Work phone #**. The **Email address** is carried over from the profile page.

Contact Info

Home Phone # Preferred Method of Contact

1 Work Phone # Created 6/27/2011 7:45 PM

Mobile # Updated 2/20/2013 12:28 PM

Other Phone #

Fax #

Emergency(P) #

Emergency(W) #

Email Address

Addresses [Add Address](#)

Address Type	Address	Confidential	Created	Updated	Actions

Agency Contact Staff Account

continued

The staff account for your EDI contact will need additional security. See below.

1 From the Navigation View go to *Agency>Staff List>Account Information*.

2 In the **User Information** screen, add the following to the **Job Function Role**. “**Billing Encounter**” and “**Create Agency Claim Batches**”. These job function roles allow the staff member to create claim batches.

3 In the **Role Attributes** mover box, add the following role attributes: “**Agency Billing**”, “**Agency H835 and H999 Management, Rate (Read Only)**”, “**Release To Billing**” and “**Service (Read Only)**”. These role attributes allows the staff member the ability to release encounters to billing. This enables the claim item creation.

1

User Information

First	Test	Last	Account
Manager Name	Mikan, Leslie, LLMM	Staff Type	Agency Staff
Title		Employment Type	

User Login ID: User Email:

Role Descriptions

System Access

Job Function Roles	Assigned Job Function Roles
<input type="text" value="Contractee Staff Administrator"/>	
<input type="text" value="Create Agency Claim Batch"/>	<input type="text" value="Create Agency Claim Batch"/>
<input type="text" value="Create Facility Claim Batches"/>	
<input type="text" value="Drug Test Results (Full Access)"/>	

Role Attributes	Assigned Role Attributes
<input type="text" value="Agency Billing"/>	<input type="text" value="Release To Billing"/>
<input type="text" value="Agency Full Access"/>	<input type="text" value="Agency Billing"/>
<input type="text" value="Assessments (Full Access)"/>	
<input type="text" value="Release To Billing"/>	

Support Ticket Notification Indicator

Allowed Emergency Access?

Emergency Login ID

Administrative Actions

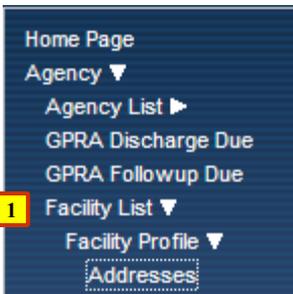
[Remove Account](#) [Reset Credentials](#) [Disable Account](#) [Expire Credentials](#)



Facility Treatment Location Address

Each billing Facility must have a valid treatment location address.

- 1 From the Navigation View go to *Agency > Facility List*.
- 2 From the **Facility List**, **Actions** column, select the [Profile](#). The **Facility Profile** screen will open. Click on the right arrow to access the **Addresses** screen.
- 3 In the **Addresses** screen, click on [Add Address](#) and select the address type of “**Facility Treatment Location**”. Complete the address information including phone number. Click “**Finish**”. Repeat for each facility.



Facility List		Add New Facility Record
Facility Name	Actions	
Administrative Unit	2 Profile Contacts Special Services Programs Addiction Services Operating Hours	
treatment unit	Profile Contacts Special Services Programs Addiction Services Operating Hours	

Addresses					Add Address
Address Type	Address	Phone	Updated	Actions	
3 Facility Treatment Location	500 Summer St N Salem, OR 97301	Work (503) 945-5555 x55555	4/23/2012	Review Delete	



Agency Payor Plan Creation

- After the Agency Profile and Agency Contact staff account have been set up, the next step is to create the payor plan(s) for the agency. Payor plan is the insurance benefit plan(s) your agency bills. You must have one benefit plan for each insurance entity.
- You will need the following information to set up a payor plan:
 - Company Name (Get from Insurance Co. as they request in the 837/CMS-1500)
 - Claim Filing Type (Medicaid, HMO, EPO etc.)
 - Payor Name (Get from Insurance Co. as they request in the 837/CMS-1500)
 - Receiver Name (Get from Insurance Co. as they request in the 837)
 - Application Receiver # (Get from Insurance Co. as they request in the 837)
 - Payor ID# (Get from Insurance Co. as they request in the 837/CMS-1500)
 - Receiver ETIN (Get from Insurance Co. as they request in the 837)
 - Submitter ETIN (Get from Insurance Co. as they request in the 837)
- Most payors will have a companion guide containing this information. Ask your insurance contact person for the guide, or instructions if they do not have a guide. See instructions on next page for requesting MMIS EDI direct billing.

Agency DMAP/MMIS EDI set up and testing process

If you are NOT currently submitting 837 files to MMIS, please see below:

DMAP requires providers send a compliant 837 file and utilize their Technical Specifications for the payer specific requirements. The Technical Specifications (TS) are posted at: <http://www.oregon.gov/OHA/edi/Pages/resources.aspx>. The TS contain only the payer specific requirements and are not representative of all requirements in the files. Creating files using only the TS does not work at all since there are so many file compliance requirements not covered there.

To bill MMIS directly, you have to sign up to do the EDI billing for your agency. Complete a Trading Partner Agreement indicating which transactions you will be using and how you will be sending them (through a clearinghouse or self-submitting). This will initiate the testing process. The first step is the outside compliance checking; this is run through an Edifecs tool called RAMP. This does not include the payer specific requirements and checks compliance only. Once this level of testing is successful, send an alert to our EDI testing team and then the file is reviewed. If this level of testing is successful, you are invited to begin business-to-business testing which includes the payer specific requirements. This level of testing is done with back and forth communication with the individual provider until all issues are resolved.

Please contact DHS.EDISupport@state.or.us if you have any questions.

Payor Plan List-Payor Plan Profile for Billing Form Type 837P

From the Navigation View go to: *Agency>Billing>Payor Plan List*.

1 Click on [Add New Payor Plan](#) to add a new plan,

or

2 Click on Profile from the [Actions](#) column to review existing plan.

3 Payor Plan Profile screen view after selecting [Add New Payor Plan](#)

4 The Plan Types shown are Medicaid (OHP), Self-Pay for clients without insurance, Group Insurance (Blue Cross Blue Shield, Providence, etc.), Medicare, Other and Government Contract. **(Government Contract is reserved for State use only).**

1

Payor Plan List						Add New Payor Plan
Company	Plan Name	CH Agency	Plan Type	HIPAA Payor ID	Billing Form	Actions
MMIS	MMIS		Medicaid	123456	837P	Profile Delete

2

Payor Plan Profile

4 Plan Type ▼

Plan Name Medicaid

Billing Form Self-pay

Company Name Group Insurance

Agency Medicare

Claim Filing Type Other

Client Confidential

Release To Billing Enabled Yes ▼

Payor Plan Type Id

HIPAA EDI Information

Payor Name

Receiver Name

Application Receiver #

HIPAA Processing Set

Segment Delimiter

Payor ID#

Receiver ETIN

Interchange Receiver #

Element Delimiter

Composite Delimiter

Administrative Actions

Cancel
Save
Finish
➔

Payor Plan List-Payor Plan Profile for Billing Form Type 837P

continued

1 **Billing Form** type 837P should be selected.

2 Enter the name of the company offering this plan.

3 **Is Authorization Required?** If pre-authorization is required, select Yes.

4 **Effective Date** – this is the effective date of this plan.

5 **Release to Billing Enabled** – Select Yes.

6 **Eligibility Inquiry Batching Enabled** – Select No.

7 **Transaction Type Code** – Chargeable or Reporting.

8 The **HIPAA EDI Information** is required for each 837 Payor Plan. Agencies should have this information in their current billing system. If you do not currently have the information, contact your payor and ask for the 837 billing format or companion guide.

9 Once completed, click the right arrow button to go to next screen.

The screenshot shows the 'Payor Plan Profile' form with the following fields and values:

- Plan Type: Group Insurance
- Plan Name: Blue Cross (JJ's site)
- Billing Form: 837P (callout 1)
- Company Name: Blue Cross/Blue Shield (JJ) (callout 2)
- Agency: [Empty]
- Claim Filing Type: [Empty]
- Client Confidential: [Empty]
- Release To Billing Enabled: Yes (callout 5)
- Eligibility Inquiry Batching Enabled: No (callout 6)
- Transaction Type Code: Chargeable (callout 7)
- Is Authorization Required?: No (callout 3)
- Effective Date: 8/1/2013 (callout 4)
- Expiration Date: [Empty]
- Reactivated Date: [Empty]

The **HIPAA EDI Information** section (callout 8) includes:

- Payor Name: Blue Cross/Blue Shield
- Payor ID#: 225566
- Receiver Name: Office Ally
- Receiver ETIN: 330897513
- Application Receiver #: 330897513
- Interchange Receiver #: 330897513
- HIPAA Processing Set: Generic 837/835 (5010)
- Segment Delimiter: ~
- Element Delimiter: *
- Composite Delimiter: :

At the bottom, there are buttons for 'Cancel', 'Save', 'Finish', and a right arrow button (callout 9).

Payor Plan – Group List

continued

Groups are created to identify specific group benefit #'s used by insurance plans. Use meaningful naming conventions when creating groups. Click on the [Manage Groups](#) link. One group for each payor plan is required. Multiple groups per plan is permitted. In this example, General is the name of the group and covers the General population.

- 1** If **Available Groups** is blank, click on [Manage Groups](#) to add a new group. You can also use [Manage Groups](#) to edit existing groups.
- 2** After clicking on [Manage Groups](#), select the group to review from the list or click on [Add Group](#).
- 3** The Group Name and Group # are required fields. Insurance agencies will give you the group name and # required for submission.
- 4** Click [Finish](#) when complete.

Group List for MMIS

Plan Type: Medicaid

Available Groups: [Blank]

Associated Groups: General

1 [Manage Groups](#) [Cancel] [Save] [Finish]

Group List for MMIS **2** [Add Group](#)

Group Name	Number	Agency	Actions
General	1		Review Delete

Group Name: [Blank] Agency: [Blank]
 Group #: [Blank] Last Updated: [Blank]
 Plan Type: [Blank] Last Updated By: [Blank]
 Covered Population: [Blank]
 Age Group: [Blank]
 Gender Specific: [Blank] [Finish](#)

Group List for MMIS [Add Group](#)

Group Name	Number	Agency	Actions
General	1		Review Delete

Group Name: **General** Agency: [Blank]
 Group #: **1** Last Updated: 4/23/2012 12:54 PM
 Plan Type: Medicaid Last Updated By: Garifalos, Nik
 Covered Population: [Blank]
 Age Group: [Blank]
 Gender Specific: [Blank] [Cancel](#) [Save](#) [Finish](#) **4**

Payor Plan – Agency Profile

continued

1 The Information bubble is indicating there is no need for the Agency Secondary Provider information.

2 The **HIPAA EDI Information** is required. All of the three fields should be completed. Typically your Federal Tax ID # is used. If the insurance company or clearing house requires something else, you should obtain this information from them. Click **Finish** when complete.

The payor plan set up is complete.

i The provider IDs indicated here are not sent on 5010 837s. **1**

Agency Profile for MMIS

Billing Form

Agency Secondary Provider # Secondary Provider # Type

2 **HIPAA EDI Information**

Submitter ETIN Application Sender # Interchange Sender #

Payor Plan List-Payor Plan Profile for Billing Form Type CMS-1500

1 Billing Form type CMS-1500 should be selected.

2 Specify your agency.

3 Is Authorization Required? If pre-authorization is required, select Yes. If pre-authorization is not required, select No.

4 Effective Date – this is the effective date of this plan.

5 Release to Billing Enabled – Select Yes.

6 The HIPAA EDI Information is greyed out because it is not needed for the CMS-1500 billing form.

7 Once completed, click the right arrow button to go to next screen.

NOTE: Do not go the next screen if this is a Self-Pay plan. A Self-Pay plan would have a Billing Form of Invoice.

Payor Plan Profile

Plan Type	Group Insurance	Is Authorization Required?	No
Plan Name	Office Ally	Effective Date	1/24/2013
Billing Form	CMS-1500	Expiration Date	
Company Name	Office Ally	Reactivated Date	
Agency	Administrative Agency		
Claim Filing Type	Commercial Insurance Co.		
Client Confidential			
Release To Billing Enabled	Yes		

HIPAA EDI Information

Payor Name		Payor ID#	
Receiver Name		Receiver ETIN	
Application Receiver #		Interchange Receiver #	
HIPAA Processing Set			
Segment Delimiter		Element Delimiter	
		Composite Delimiter	

Administrative Actions

Cancel Save Finish

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Last Revised Date: 5/26/2016

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Payor Plan – Agency Profile

The Payor Plan – Group List setup is the same for all Billing Form types.

1 Agency Primary Provider # and Primary Provider # Type - this is the National Provider ID number.

2 Agency Secondary Provider # and Secondary Provider # Type – this is the Employee Identification number (Federal Tax ID #).

3 The **HIPAA EDI Information** is greyed out because it is not required for the CMS-1500 billing form.

Click **Finish** when complete.

The payor plan set up is complete.

Agency Profile for Office Ally

Billing Form

1 Agency Primary Provider # Primary Provider # Type

2 Agency Secondary Provider # Secondary Provider # Type

3 **HIPAA EDI Information** (greyed out)

Submitter ETIN Application Sender # Interchange Sender #

Payor Plan List-Payor Plan Profile for plan with Authorization Required.

1 When a payor requires pre-authorization, set up the plan with “Is Authorization Required?” set to YES.

2 Complete the Payor Plan Profile as shown in prior pages.

2

Payor Plan Profile

Plan Type	Other	1 Is Authorization Required?	Yes
Plan Name	Pre-Authorization Test Plan	Effective Date	5/23/2012
Billing Form	CMS-1500	Expiration Date	
Company Name	State Or Oregon	Reactivated Date	
Agency			
Claim Filing Type			
Client Confidential			
Release To Billing Enabled	Yes		

HIPAA EDI Information

Payor Name	OHA/AMH	Payor ID#	123456
Receiver Name		Receiver ETIN	
Application Receiver #		Interchange Receiver #	
HIPAA Processing Set			
Segment Delimiter		Element Delimiter	
		Composite Delimiter	

Administrative Actions

Cancel Save Finish

NOTE: Additional information regarding creating authorization vouchers, encounters and billing for pre-authorized services can be found in their specific topic category within this document.

Agency Rate Setup

- Cloning Rates-Adding Rates
 - Cloning existing rates/Adding new rates
- Agency Rate Types
 - Setting up exiting rates
 - Adding new rates

Cloning Rates – Adding Rates

Rates should be set up for each payor plan.

- 1 In the navigation view select *System Administration* > *Rates*. This will navigate to the [Agency Rate Search](#) screen.
- 2 In the Plan drop down menu select “MMIS” then click [Go](#).
- 3 This will populate the Agency Rate List with all published Medicaid service rates.
- 4 In the [Actions](#) click “[Clone](#)” next to the rate to add to your agency.
- 5 Click on [Add Rate](#) if a rate does not exist for the desired service. This will create a rate based on selected services.

Agency Rate Search

Agency

Service

Plan **MMIS**

Rate Per Unit

Duration Type

Duration

Effective Date

Expiration Date

5 [Clear](#) [Go](#)

Agency Rate List [\(Export\)](#) [Add Rate](#)

Svc #	Rate #	Service Desc	Procedure	Agency Name	Plan	Rate/Unit	Effective	Expiration	Unit Desc	Active	Actions
1048	100059	90801 - Psychiatric Diagnostic Interview Exam	90801		MMIS	\$140.94	11/1/2011		1 unit = per service	4 Yes	Profile Clone
1431	100060	90802 - Psychiatric Diagnostic Interview Exam, interactive methods	90802		MMIS	\$140.94	11/1/2011		1 unit = per service	Yes	Profile Clone
1431	100118	90802 - Psychiatric Diagnostic Interview Exam, interactive methods	90802	Administrative Agency	MMIS	\$140.94	11/1/2011		1 unit = per service	Yes	Profile Clone
1400	100061	90804 - Indiv outpt psychotherapy, insight-based/behavior mod./supportive; 20-30 mins. face/face	90804		MMIS	\$70.47	11/1/2011		1 unit = per service	Yes	Profile Clone
1049	100122	90805 - Indiv psychotherapy, insight oriented with med eval and mgmt; 20-30 mins.	90805		MMIS	\$70.47	11/1/2011		1 unit = per service	Yes	Profile Clone
1050	100123	90806 - Indiv outpt psychotherapy, insight-based/behavior mod./supportive; 45-50 mins. face/face	90806		MMIS	\$98.11	11/1/2011		1 unit = per service	Yes	Profile Clone
1425	100124	90807 - Indiv psychotherapy, insight oriented with med eval and mgmt; 45-50 mins.	90807		MMIS	\$105.70	11/1/2011		1 unit = per service	Yes	Profile Clone
		90808 - Indiv outpt psychotherapy, insight-							1 unit = ner		Profile

Agency Rate Types

- 1 **Rate Per Unit:** Verify or change the Rate Per Unit
- 2 **Service:** Verify or change the Service
- 3 **Description:** Add the description for the rate per unit. Example: 1 unit = 1 hour.
- 4 **Effective Date:** This is important. The date cannot be later than a plan date. Ensure the plan effective date and rate Effective Dates are the same.
- 5 **Rate Type:** Agency-Plan Specific is specific to your agency and selected plan. Plan Specific relates to the plan selected and can be used by all Agencies using this plan. Agency Standard pertains to the agency only and is not related to a specific plan. These rates can be used with any payor plan. (This is the best option if your rates are the same for all plans)
- 6 **Agency:** Use when Agency-Plan Specific Rate Type is selected. Auto-fills with users agency.
- 7 **Facility:** You can chose to create rates by Facility. This is only useful if facilities have different rates.
- 8 **Plan:** Select the plan for the service rate. If this rate is valid for more than one plan, clone the rate again and create for each plan, or use Agency Standard type.
- 9 **Note:** The Update Date, Updated By, Created Date and Created By fields are all greyed out when you select [Clone](#). If you click [Profile](#) these fields will be populated. Do not change the rate if the fields are populated unless you are editing an existing rate. Click **Cancel** and select [Clone](#) from the [Actions](#) column.

The screenshot shows the 'Agency Rate Profile' form with the following fields and values:

- Service Section:**
 - Service #: 65
 - Procedure Code: H0001
 - Rendering Provider: No
 - Date Span: No
 - Effective Date: 8/1/2011
 - Expiration Date:
 - Created Date: 9/23/2011
 - Description: Alcohol and/or Drug Assessment
 - Measure Type: Unit
 - Modifier 1: HF
 - Modifier 2:
 - Modifier 3:
 - Modifier 4:
- Agency Rate Profile Section:**
 - Rate #: [Greyed out]
 - Rate Per Unit: \$140.94 (Callout 1)
 - Service: H0001/HF/Alcohol and/or Drug Assessment (Callout 2)
 - Description: 1 unit = per assessment (Callout 3)
 - Duration Type: [Greyed out]
 - Duration: [Greyed out]
 - Effective Date: 1/1/2011 (Callout 4)
 - Expiration Date: [Greyed out]
 - Rate Type: Agency - Plan-Specific (Callout 5)
 - Agency: Administrative Agency (Callout 6)
 - Facility: [Greyed out] (Callout 7)
 - Plan: MMIS (Callout 8)
 - Updated Date: [Greyed out]
 - Updated By: [Greyed out]
 - Created Date: [Greyed out]
 - Created By: [Greyed out]
- Buttons:** Cancel, Save, Finish
- Callout 9:** Points to the bottom of the form, indicating the 'Clone' action.

NOTE: The set up is the same for cloning rates or adding new rates. Follow Steps 1-9. If the service you need is not present, please contact OWITS.SUPPORT@state.or.us

Client Benefit Plan Enrollment

- Client Group Enrollment (CGE)
 - Enrolling Client in Payor Plan.
 - Client can be enrolled in more than one plan.
- Client Encounter
 - Billing encounters are created for services provided.
 - Encounters capture billing information such as:
 - Services/Programs.
 - Rates/Units billed.
 - Treatment plan information.
 - Progress Notes.
- Release to Billing
 - Release To Billing Actions.
 - Staff member security Job Functions and Roles

Client Group Enrollment

Clients must be enrolled in a Benefit Plan to create a claim item and bill for services. Client must also have an address type of “Client Billing”.

1 Client List>Client Profile> Client Group Enrollment. The Payor List screen will open. Click on Add Benefit Plan Enrollment.

2 The Benefit Plan/Private Pay Billing Information screen will open.

3 In the Plan-Group Drop down field, select the clients payor plan.

4 Coverage Start date must be the actual start date of the clients coverage for the plan.

5 In the Relationship to Subscriber/Responsible Party field if you select “Self” The clients information will auto populate from the client profile record.

6 The Subscriber # field does not auto populate. For Medicaid clients this number would be the OHP #. If clients are private pay, the number would be the medical benefit plan #.

7 Click Save when complete

1

Payor List								Add Benefit Plan Enrollment
Plan	Group	Contract	Subscriber/ Acct#	Subscriber/ Resp Party	Start Date	End Date	Actions	

2

Benefit Plan/Private Pay Billing Information

3 Plan-Group **MMS-General** Payor Type **Medicaid**

4 Coverage Start **8/28/2012** End Payment Scale

Eligibility Category 5 Relationship to Subscriber/ Responsible Party **Self**

Subscriber/ Responsible Party:

First Name **Test** Middle Last Name **Client**

Birthdate **1/1/1970** Gender **M-Male** 6 Subscriber # **This is the OHP #**

Address 1 **123 Main Street**

Address 2

City **Columboa** State **Maryland** Zip **21046-1111**

7

- 3
- Client Self Pay-Self Pay Group B
 - Office Ally 837P-General
 - Office Ally CMS-1500-General
 - Providence-Pre-Auth Group

- 5
- Self
 - Spouse
 - Life Partner
 - Child
 - Employee
 - Other Relationship
 - Unknown

NOTE: If the Relationship to Subscriber/Responsible Party is not Self, the Client Profile>Contact Info>Address Information must contain a Client Billing address.

Client Profile- Authorization Voucher

Client enrolled in plans requiring pre-authorization must have an authorization “Voucher” Created.

1 *Client List>Client Profile/Voucher.*
The **Voucher List** screen will open.
Click on “**Add New Voucher Record**”

2 **Group Enrollment-** in the drop down field, select the pre-auth payor.
The plan will populate based on your selection.

3 **Voucher #** is the authorization # assigned by the benefit plan agency (BCBS, Medicare, etc.)

4 **Effective Date/End Date** is the date given by the benefit plan agency.
Important: potential for rejected or denied claims if incorrect dates are entered.

5 **Status** Defaults to Active when creating a new voucher.

6 **Date Approved** by benefit plan agency.

7 **Comments:** add any special conditions or comments.

Click SAVE.

8 **Add Service:** click here to add approved services.

Voucher List 1 Add New Voucher Record										
Voucher #	Payor	Status	Effective Date	End Date	Vouched Amount	Encumbered	Expended	Available	Last Activity Date	Actions

Voucher for bar, granola

2 { Group Enrollment

Plan

3 Voucher #

Administrating Agency Administrative Agency

4 { Effective Date

End Date

Comments

7

5 Status

Contract

6 Date Approved

Updated Date

Updated By

Vouched Services List **8** Add Service

Service	Vouched Units	Encumbered	Expended	Available Units	Actions

Total Vouched

Total Encumbered:

Total Expended:

Total Available:

Client Profile- Authorization Voucher Services

Client enrolled in plans requiring pre-authorization must have a authorization “Voucher” Created.

1 Service – Select the service that is associated with this voucher.

2 Voucher # defaults from previous information entered.

3 Voucher Units - enter the number of units authorized by this voucher. The # Used Units will decrease as services are provide.

4 Authorized Amount – this field is greyed out and not used.

5 This shows the completed voucher information

The screenshot shows a form titled "Vouched Services for bar, granola". It contains the following fields: "Service" (a dropdown menu), "Voucher #" (a text box containing "13"), "# Vouched Units" (a text box containing "0"), "# Used Units" (a text box containing "0"), and "Authorized Amount" (a greyed-out text box). Below the form are three buttons: "Cancel" (red), "Save" (green), and "Finish" (blue). Red boxes with numbers 1 through 4 are placed next to the corresponding fields.

The screenshot shows the same form as above, but with updated values. The "Service" dropdown is now set to "H0005/HF - Alcohol and/or drug services; group counseling by a clinician". The "# Vouched Units" field now contains "10". The "# Used Units" field still contains "0". The "Authorized Amount" field remains greyed out. A red bracket on the left side of the form groups the "Service", "# Vouched Units", and "# Used Units" fields, with a red box containing the number "5" next to it. The "Cancel", "Save", and "Finish" buttons are still present at the bottom.

Client Profile- Authorization Voucher Services

1

Voucher for bar, granola

Group Enrollment	<input type="text" value="Pre-Auth"/>	Status	<input type="text" value="Active"/>
Plan	<input type="text" value="Pre-Authorization Test Plan"/>	Contract	<input type="text" value=""/>
Voucher #	<input type="text" value="46123"/>	Date Approved	<input type="text" value="6/13/2013"/>
Administering Agency	<input type="text" value="Administrative Agency"/>	Updated Date	<input type="text" value="6/13/2013 1:57 PM"/>
Effective Date	<input type="text" value="6/13/2013"/>	Updated By	<input type="text" value="Mikan, Leslie, LLMM"/>
End Date	<input type="text" value="9/11/2013"/>		

Comments
 Billing must be accompanied by signed detailed progress note.

Vouched Services List [Add Service](#)

Service	Vouched Units	Encumbered	Expended	Available Units	Actions
H0005/HF - Alcohol and/or drug services; group counseling by a clinician	10	0.00	0.00	10.00	Edit Delete

Total Vouched:
 Total Encumbered:
 Total Expended:
 Total Available:

Actions
[Close](#)

1 The completed voucher is ready to save. The voucher will be used in the creation of the claim item. Once the encounter has been created and the Release to Billing has been selected, the payor plan, Pre-Authorization Test Plan (example) will not allow services billed unless they are included in a voucher, the voucher effective date is valid and the # of units is valid. Once the units are depleted, the system will not allow claims to be created for the selected service or payor plan for the client.

Client Encounter

- 1 Go to *Client List>Client Profile/Activity List/Encounters*. Click on Add Encounter Record.
- 2 Select the appropriate service for billing. The **Service** selected must have a rate set up in the System Administration>Rate section.
- 3 The **Start Date** is the date of the service rendered. It cannot pre-date the Group Enrollment Date, Payor Plan effective date, Service effective date, Service Rate effective date or the Program Enrollment date.
- 4 The **Rendering Staff** should have valid phone number and NPI number in the Staff account set up. The NPI is required for those services requiring a qualified rendering provider. Verify the correct rendering staff populates this field. To change your selection use the drop down menu and select appropriate staff member.
- 5 You must sign your note before you can release to billing. To do so, type your note in the “Unsigned Notes” area and then click on “**Sign Note**”
- 6 After completing all required fields and signing your note, click **SAVE** and go to the [Administrative Actions](#) area; click on [Release to Billing](#). This will take you to the **Release to Billing** screen.

The screenshot shows a web-based form titled "Encounter for Demo, Enrollment". The form is divided into several sections. At the top, there are fields for "Note Type", "ENC ID", "Created Date", "Service", and "Program Name". The "Service" field is highlighted with a yellow background and a red callout box labeled "2". Below these are fields for "Service Location", "Start Date", "End Date", "Start Time", "End Time", "Duration", "Emergency", and "# of Service Units/Sessions". The "Start Date" field is highlighted with a yellow background and a red callout box labeled "3". A red bracket labeled "1" encompasses the "Service" and "Program Name" fields. Below the date and time fields is a "Pregnant No" field. The "Diagnoses for this Service" section contains "Primary", "Secondary", and "Tertiary" dropdown menus, with "303.90-Alcohol Dependence(DSM)" selected in the primary field. The "Rendering Staff" section has "Mikan, Leslie, LLMM" selected in the "Rendering Staff" dropdown, with a red callout box labeled "4". Below this are "Supervising Staff" and "Referring Phys" dropdowns. The "Unsigned Notes" section is a large text area with a scroll bar. At the bottom of this section are "Add Note" and "Sign Note" buttons, with the "Sign Note" button highlighted by a red callout box labeled "5". Below the "Unsigned Notes" section is the "Signed Notes" section, which is currently empty. At the bottom of the form is the "Administrative Actions" section, which contains a "Release to Billing" button highlighted by a red callout box labeled "6". At the very bottom of the form are "Cancel", "Save", and "Finish" buttons, along with a right-pointing arrow.

Release to Billing

- 1 In the **Client Group Enrollment** drop down menu, select the Group/Plan that is being billed for this service.
- 2 Click **Finish**. The system will return to the **Encounter Search** screen.
- 3 The encounter created will display in the **Encounter List** with the status of “**Released**”.
- 4 If the status is “**Not Released**”, go to the **Actions** column and click “**Review**”. This will take you back to the encounter. Repeat the **Release to Billing** instructions on prior screen and complete all steps.

i The Client Group Enrollment dropdown reflects Client Profile>Payor Group Enrollments effective on the encounter date of service.

Release To Billing

Client Group Enrollment: General [MMIS] 1

2 **Finish**
Cancel

Encounter Search

Start Date: End Date:

Rendering Staff: Service:

Encounter Status: Program:

Clear **Go**

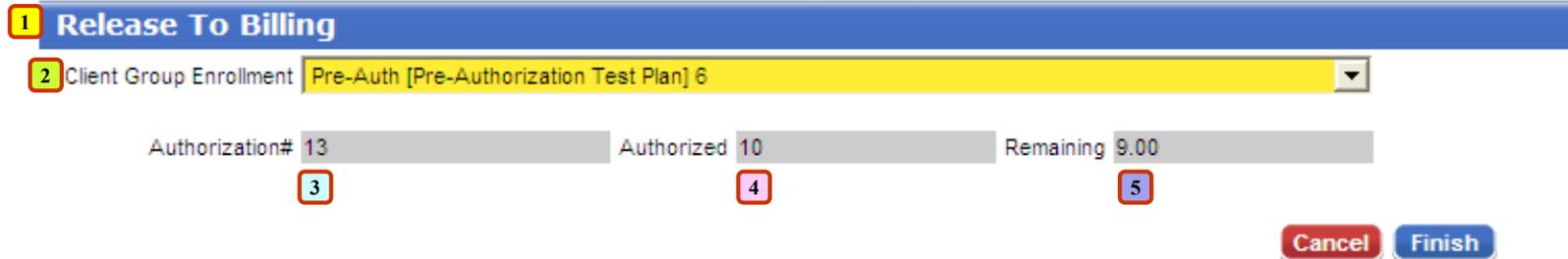
Encounter List(Export) [Add Encounter Record](#)

Svc Date	Service	ENC ID	Rendering Staff	Program Name	Status 3	Actions 4
8/28/2012	Service 2	1056	Mikan, Leslie, LLMM	TEDS Program 1	Released	Review

Release to Billing with Voucher

- 1** The “**Release To Billing**” screen appears slightly different when billing a pre-authorization plan. The Authorization unit information for the service appears.
- 2 Client Group Enrollment:** The drop down menu displays the Pre-Auth Group/Plan. The client voucher information will display after the plan has been selected.
- 3 Authorization #:** This is the Voucher # entered in the Client Profile Voucher. This number should be assigned by the payor. Your claim could be rejected or denied if this number is not entered or obtained correctly.
- 4 Authorized:** This field displays the # of Authorized units. This number should be assigned by the payor.
- 5 Remaining:** This field displays the # of units remaining after billing. This is a running number based on total number of units billed for the life of the Voucher.

 The Client Group Enrollment dropdown reflects Client Profile>Payor Group Enrollments effective on the encounter date of service.



1 Release To Billing

2 Client Group Enrollment Pre-Auth [Pre-Authorization Test Plan] 6

Authorization# 13 Authorized 10 Remaining 9.00

3 **4** **5**

Cancel Finish

Agency Billing

- Claim Item List
 - Claim Item Action: Review:
 - Change Units, Group Enrollment, Service or Location.
 - Awaiting Review, Hold, Reject (Back Out).
 - Create Batch
 - Select Claim Items to batch.
- Claim Batch List
 - Claim Batch Actions
 - Bill It
 - Administrative Actions
 - 837 download
 - CMS-1500 form
 - Provider Claim Batch Profile errors
 - EOB Transactions
 - Encounter Reject (Back Out)

Claim Item List

1 **Claim Item Search**

Plan Group Enrollment ENC ID
Client First Name Client Last Name Charge
Subscriber/Resp Party First Name S/R Party Last Name Service
Subscriber/Resp Party Account # Rendering Staff Service Date
Voucher #
Item Status **2** Facility

[Create Batches](#) **4**

Claim Item List (Export)

Item #	Client Name	Service Date	Service	Duration	Status	Release Date	Charge	Actions
637	Demo, Enrollment	7/25/2012	0002		Released	8/28/2012	\$100.00	Profile 3

Releasing an encounter to billing generates a “Claim Item”. Claim items are batched by specific Plans.

- 1** From the navigation view click on *Agency>Billing>Claim Item List*. This will take you to the Claim Item Search screen.
- 2** Filter your search by **Item Status**. Using the drop down field select “**Released**”. This will display all claims released but not batched. You can view all claims by selecting the blank (white) area in the **Item Status** drop down list.
- 3** To review claim items and make changes before you batch, go to the **Actions** column , click [Profile](#). (see next page)
- 4** To generate and run the batch process, click on **Create Batches**. **Important! Do not create batches for Self-Pay Benefit Plans.**

Claim Item Adjustment

Profile for Claim Item # 625 for Demo, Enrollment

ENC ID: 1008	Delivered Service: 0002
Program: TEDS Program 1	Service Start: 8/2/2012 12:00 AM
Diagnoses: 303.90 / /	Service End: 8/2/2012 12:00 AM
Pregnant: No	Duration:
Status: Released	# Sessions/Units: 2
	Rendering Staff: Mikan, Leslie, LLMM

1 Service Fee: Billing Units X Rate / Unit =

2 Group Enrollment:

3 Payor Billing Service:

4 Service Location:

Unit Desc:

5 Administrative Actions:

Cost Center:

Billing Note:

Encounter Post Date:

Created Date:

Before the claim item is batched, you can make the following changes:

- 1** Change billing units. The total fee will change based on the # of units.
- 2** Change Group Enrollment (**not recommended**).
- 3** Change Service. The service must have a rate set up for the payor plan group. (**not recommended**).
- 4** Change Service Location
- 5** Place in [Awaiting Review](#), [Hold](#) or [Reject \(Back Out\)](#). Rejecting creates a credit/debit entry for this claim for the billed amount. If you have to change the Group Enrollment or Billing service, it is best to reject the claim and create a new Encounter (see Claim Item Adjustment –Reject (Back Out) at the end of this section). Click **Finish** to return to Claim Item List screen.

Claim Item Adjustment

Profile for Claim Item #953 for bar, granola

ENC ID: 1532	Delivered Service: H0001/HF
Program: TEDS Program 1 male	Service Start: 6/6/2013 12:00 AM
Diagnoses: 303.00 / /	Service End: 6/6/2013 12:00 AM
Pregnant: No	Duration:
Status: Released	# Sessions/Units: 1
	Rendering Staff: Mikan, Leslie, LLMM

Service Fee		Cost Center	<input type="text"/>
2	Billing Units <input type="text" value="1.00"/> X Rate / Unit <input type="text" value="\$189.00"/> = <input type="text" value="\$189.00"/>	Billing Note	<input type="text" value="20"/>
Group Enrollment	<input type="text" value="Pre-Auth [Pre-Authorization Test Plan] 6"/>	Encounter Post Date	<input type="text" value="6/12/2013"/>
Payor Billing Service	<input type="text" value="H0001/HF - Alcohol and/or Drug Assessment: H0001/HF"/>	Created Date	<input type="text" value="6/12/2013 4:41 PM"/>
Service Location	<input type="text" value="Outpatient Hospital"/>		
Unit Desc	<input type="text" value="1 unit = per assessment"/>		
1	Voucher <input type="text" value="13"/> Authorized <input type="text" value="10.00"/> Remaining <input type="text" value="8.00"/>		
		3	

Administrative Actions	
Awaiting Review	Hold Reject (Back Out)

The Claim Item for Pre-Auth services looks the same with following exception:

- 1 Voucher information is displayed.
The Claim can be edited as explained on prior page.
- 2 If you change the Billing Units, the 3 **Remaining** units will reflect the new unit count.

Agency Claim Item List

continued

- 1 After clicking [Create Batches](#) in the **Claim Item List** screen, the **Choose Plans(s) for Batching** screen will open.
- 2 The **Available Plans** box will display all Plans with valid Claims. Select the plan(s) to batch by clicking on the plan in the **Available Plans** box. This will highlight the plan.
- 3 Click the right arrow button to move the plan to the **Selected Plans** Box.
- 4 Click **Go**. This will return you to the **Claim Item List**.

NOTE: If the plan you were expecting is missing, there are no valid claims released. Go back to the encounter screen and verify you created and released the encounter.

Choose Plan(s) for Batching 1

Available Plans Selected Plans

Client Pay
MMIS 2

3 >

Cancel Clear Go

Choose Plan(s) for Batching

Available Plans Selected Plans

Client Pay

MMIS 3

<

Cancel Clear Go 4

Agency Claim Batch-Bill It

continued

To access the **Provider Claim Batch List**, from the navigation view click on *Agency>Billing>Claim Batch List*.

1 Filter the view by selecting or entering one of the following : **Plan Name, Billing Form, Batch #, Created Date** or **Status**. The status for recently created batches is “**Released**”.

2 To remove a Claim Item from a batch, locate the batch# in the **Claim Batch List**. In the **Actions** column, click on “[Claim Items](#)”.

3 The **Claim Item List for Batch (#)** will return all claim items in the batch. 1 or more claim items can be removed from a batch by clicking in the checkbox next to the claim #, click **[Remove From Claim Batch](#)**. There is no warning or message asking if you REALLY want to remove claim item so be careful. Once the batch has been created you will need to “**Bill It**”. This action is found in the batch [Profile](#). (next page)

Provider Claim Batch List

Plan Name Created Date 8/29/2012
Billing Form 837P Transmit Date
Batch # Status Released

Claim Batch List (Export)

Batch #	Status	Batch For	Billing Form	Order	Charges	Service Mo/Yr	Created	Transmit	Actions
374	Released	MMIS	837P	P	\$100.00	Aug 2012	8/29/2012		Claim Items Profile
375	Released	MMIS	837P	P	\$100.00	Jul 2012	8/29/2012		Claim Items Profile

Claim Item List (Export)

Claim #	Item #	Client Name	CPT	Status	Auth #	Cost Center	Charge	Actions

Claim Item List for Batch 374 (Export) [Remove From Claim Batch](#)

<input type="checkbox"/>	Claim #	Item #	Client Name	CPT	Status	Auth #	Cost Center	Charge	Actions
<input checked="" type="checkbox"/>	591	633	Demo, Enrollment	0002	Batched	123456		\$100.00	Profile

Agency Claim Batch-Bill It

continued

Provider Claim Batch List

Plan Name Created Date
Billing Form Transmit Date
Batch # Status

Claim Batch List *(Export)*

Batch #	Status	Batch For	Billing Form	Order	Charges	Service Mo/Yr	Created	Transmit	Actions
374 1	Released	MMIS	837P	P	\$100.00	Aug 2012	8/29/2012		Claim Items Profile 2
375	Released	MMIS	837P	P	\$100.00	Jul 2012	8/29/2012		Claim Items Profile

Claim Item List *(Export)*

Claim #	Item #	Client Name	CPT	Status	Auth #	Cost Center	Charge	Actions

The next step in the process is to [Bill it](#). To access the [Bill it](#) Administrative Action:

- 1** In the **Claim Batch List**, locate the batch#.
- 2** In the **Actions** column, click on [Profile](#). This will open the **Provider Claim Batch Profile** screen. *(next page)*

Agency Claim Batch – Bill it

continued

Provider Claim Batch Profile

Batch #	374	Charge Amount	\$100.00
Batch For	MMIS	Status	Released
Created By	Mikan, Leslie, LLMM	Created Date	8/29/2012 12:08 PM
Updated By	Mikan, Leslie, LLMM	Updated Date	8/29/2012 12:08 PM
Billing Form	837P	Transmit Date	
Order	Primary	Ignore Warnings	No
Service Month/Year	8/1/2012		
	HIPAA Processing Set		
	837 File Status		
	Transmission Message		

Errors List *(Export)*

Batch #	Level	Message	Created	Claim #	Item #

Administrative Actions

[Awaiting Review](#) [Hold](#) [Void](#) [Bill It](#)

2 3 4 1

Cancel Save Finish

1 Scroll to the bottom of the **Provider Claim Batch Profile** screen. In the **Administrative Actions** area, click on [Bill It](#). The “Bill It” feature starts the 837 file or CMS-1500 generation process, depending on the plan billing type. Click Finish when complete. The other Actions available are: (*Detailed instructions for each Action type on next page*)

2 • [Awaiting Review](#)

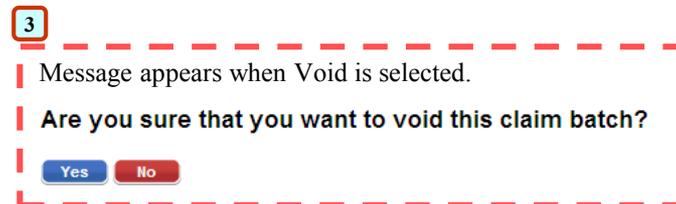
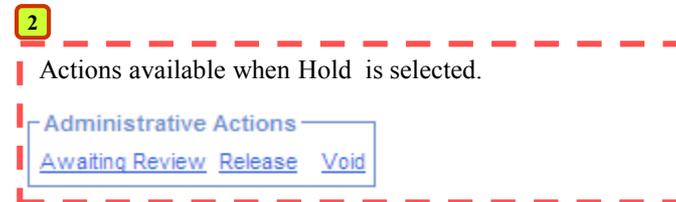
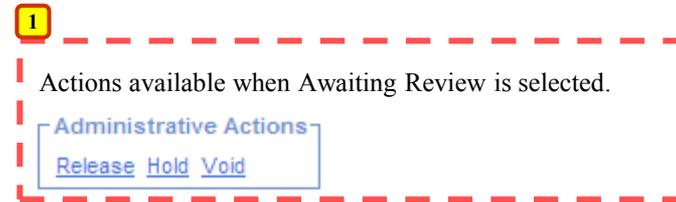
3 • [Hold](#)

4 • [Void](#)

Agency Claim Batch-Administrative Actions

- 1** [Awaiting Review](#): Changes the status to Awaiting Review. Once the claim has been reviewed, your [Administrative Actions](#) change. Selecting [Release](#) changes the Administrative Actions, enabling the [Bill It](#) action. (see box **4**)
- 2** [Hold](#): Places claim on hold and can only be released by reviewing claim and selecting [Release](#) from [Administrative Actions](#)
- 3** [Void](#): Voids batch and removes claim items. A message appears asking if you are sure you want to void.
- 4** [Release](#): Releases Batch and original Actions are available.

The [Administrative Actions](#) can be changed until [Bill It](#) has been selected.

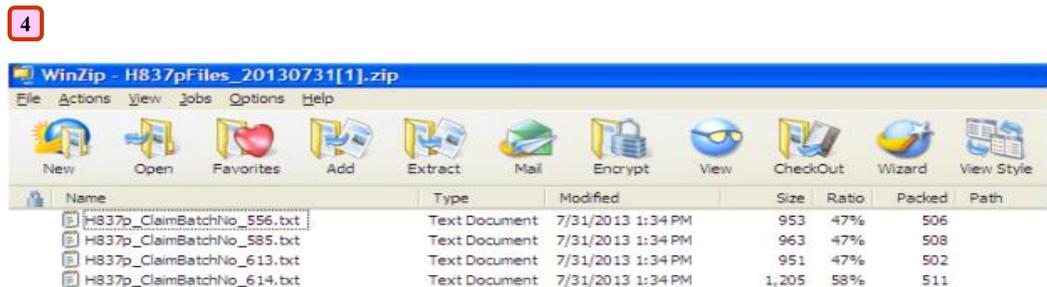
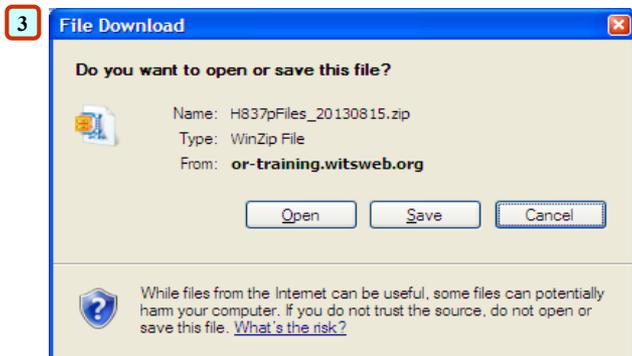


Claim Batch List - 837 download (multiple batches)

Claim Batch List (Export) 2 Download 837										
Batch #	<input checked="" type="checkbox"/>	Status	Batch For	Billing Form	Order	Charges	Service Mo/Yr	Created	Transmit	Actions
556	<input checked="" type="checkbox"/>	Billed	Office Ally 837P	837P	P	\$171.00	May 2013	6/5/2013	6/5/2013	Claim Items Profile
585	<input checked="" type="checkbox"/>	Billed	Office Ally 837P	837P	P	\$79.32	Jun 2013	6/20/2013	6/20/2013	Claim Items Profile
613	<input checked="" type="checkbox"/>	Billed	Office Ally-837P Janelle	837P	P	\$100.00	Jul 2013	7/30/2013	7/30/2013	Claim Items Profile
614	<input checked="" type="checkbox"/>	Billed	Office Ally-837P Janelle	837P	P	\$60.00	Jul 2013	7/30/2013	7/30/2013	Claim Items Profile

After selecting [Bill it](#) , the 837 file generation takes approximately 15 minutes to process. Change the Status to **Billed** to see the list of Claim Batches that have been billed. Note the Transmit date field is populated indicating the process is running.

- 1 Once the 837 file has been generated, a check box becomes viewable (available). Either select the check box in the banner to select all claim boxes, or select individual claims to download.
- 2 After selecting claims to download, click on the Download 837 link. This will create a zipped file with all the claims in it.
- 3 You will receive a message asking if you want to Open or Save the file. Save the file to your desktop or a drive to have available for sending to your clearing house or the company you are billing.
- 4 This is what you will see if you click Open on the zipped file download.



Claim Batch List - 837 download (single batch)

To process a single batch file, click on “Profile” for the batch to be processed.

The **Provider Claim Batch Profile** screen will open. Scroll to the bottom of the page. In the [Administrative Actions](#) area, click on [Download 837](#). **1** The **File Download** window will open.

2 In the **File Download** window, Click on **Save**.

Provider Claim Batch Profile

Batch #	366	Charge Amount	\$100.00
Batch For	MMIS	Status	Billed
Created By	Mikan, Leslie, LLMM	Created Date	8/27/2012 6:07 PM
Updated By	Mikan, Leslie, LLMM	Updated Date	8/27/2012 6:10 PM
Billing Form	837P	Transmit Date	8/27/2012 6:09 PM
Order	Primary	Ignore Warnings	No
Service Month/Year	4/1/2012	HIPAA Processing Set	Generic 837/835 (5010)
		837 File Status	Generated
		Transmission Message	

Errors List [\(Export\)](#)

Batch #	Level	Message	Created	Claim #	Item #

Administrative Actions

[Download 837](#) **1**

Finish



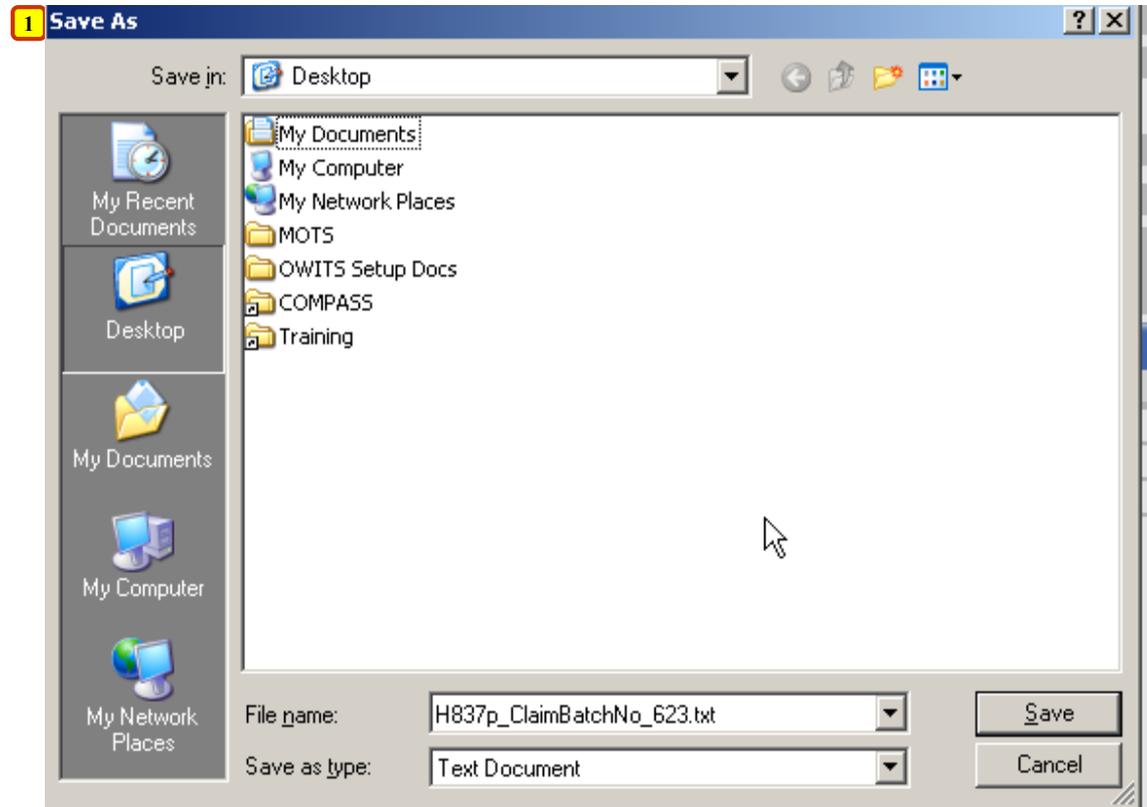
Claim Batch List - 837 download

continued

1 The **Save As** opens with the default **File Name** of “**H837p_ClaimBatchNo_XXXXX.txt**”. The XXXXX will be the specific batch number.

You can rename the batch if you choose. The naming format is up to each agency and/or their payors (MMIS, OHP, Blue Cross Blue Shield, etc.)

2 Selecting **Open** in the **File Download** window will open the actual 837 file. Sample on next page



837 file Open

3

```
ISA*00*          *00*          *ZZ*MB001234      *ZZ*ORDHS
*120523*0330*^*00501*000000291*0*P*:*~
GS*HC*MB002345*ORDHS*20120523*033019*291*X*005010X222A1~
ST*837*0001*005010X222A1~
BHT*0019*00*291*20120523*0330*CH~
NM1*41*2*Administrative Agency*****46*MB003456~
PER*IC*Huber, Michael*TE*5555555555*EM*michael.huber@state.or.us~
NM1*40*2*OR-MMIS*****46*OR-MMIS~
HL*1**20*1~
NM1*85*2*Administrative Agency*****XX*1447567755~
N3*500 Summer Street~
N4*Salem*OR*123450000~
REF*EI*121231231~
HL*2*1*22*0~
SBR*P*18*****HC~
NM1*IL*1*Enrollment*Demo****MI*123123~
N3*X~
N4*X*OR*123450000~
DMG*D8*19800101*H~
NM1*PR*2*OR-MMIS*****PI*OR-MMIS~
CLM*WITS488*100***22:B:1*Y*Y*Y*Y~
REF*EA*M119033ED338100~
HI*BK:30390~
LX*1~
SU1*HC:0002*100*UN*1***1~
DTP*472*D8*20120425~
REF*6R*530~
NM1*82*1*Huber*Michael*****XX*1447567755~
NM1*77*2*Administrative Unit~
N3*X~
N4*X*OR*123450000~
SE*29*0001~
GE*1*291~
IEA*1*000000291~
```

NOTE: To the left is a sample of the 837 file download. The sample is formatted for easy viewing.

Claim Batch List – CMS-1500 form

- 1** Billing Form type of CMS-1500 opens a window immediately after billing. Selecting **No** allows a user to print directly onto a blank CMS-1500 form. Select **Yes** to generate a printable view, PDF CMS-1500 form, allowing you to either save the file to your local computer or print.

1 **Would you like to print the background image of the CMS 1500 in addition to the data?**

***Note: Selecting "No" allows a user to print directly onto a blank 1500 form. You may need to adjust your printer setting to ensure the data lines up with the form properly. This form was designed to print with no scaling and auto rotate and center box not checked.*

NOTE: Later in this document is the Sample of the CMS-1500 completed PDF form. If the payor required pre-authorization, the clients voucher (authorization #) will print in box 23 PRIOR AUTHORIZATION NUMBER in the form.

- 2** The **Administrative Actions** for the CMS-1500 are [Reprint](#) and [Billing Process Complete](#). Once selecting the [Billing Process Complete](#) the [Reprint](#) is no longer available for printing or viewing.

2 **Administrative Actions**

[Billing Process Complete](#) [Reprint](#)

Sample CMS-1500 print view

Blue Cross Blue Shield

1500

HEALTH INSURANCE CLAIM FORM

Approved for National Health Care Providers Only

1. Insured Name: Smith, Jane 2. Insured Address: 123 The Street 3. Insured City: Portland 4. Insured State: OR 5. Insured Zip: 97201		6. Date of Service: 07 15 1900 7. Place of Service: 123 The Street 8. Referring Physician: Dr. Smith 9. Referring Physician Address: 456 Main Street 10. Referring Physician City: Portland 11. Referring Physician State: OR 12. Referring Physician Zip: 97201		13. Carrier: Blue Cross Blue Shield 14. Policy Number: 123456789 15. Group Number: 987654321 16. Member ID: 111223344 17. Identification Number: 555666777	
18. Diagnosis: 001234 19. Procedure: 567890 20. Other Information:		21. Signature on File: [Signature] 22. Date: 07 15 1900		23. Signature on File: [Signature] 24. Date: 07 15 1900	
25. Physician or Supplier Information:		26. Patient and Insured Information:		27. Carrier Information:	
28. Physician Name: Dr. Smith 29. Physician Address: 456 Main Street 30. Physician City: Portland 31. Physician State: OR 32. Physician Zip: 97201		33. Patient Name: Smith, Jane 34. Patient Address: 123 The Street 35. Patient City: Portland 36. Patient State: OR 37. Patient Zip: 97201		38. Carrier Name: Blue Cross Blue Shield 39. Carrier Address: 789 Main Street 40. Carrier City: Portland 41. Carrier State: OR 42. Carrier Zip: 97201	
43. Billing Information:		44. Payment Information:		45. Other Information:	
46. Billing Code: 123456789 47. Billing Date: 07 15 1900 48. Billing Amount: 50.00		49. Payment Code: 987654321 50. Payment Date: 07 15 1900 51. Payment Amount: 0.00		52. Other Information:	

SAMPLE

Provider Claim Batch Profile errors

Provider Claim Batch Profile

Batch #	302	Charge Amount	\$100.00
Batch For	MMIS-WBC	Status	Batch Processing Error
Created By	Mikan, Leslie, LLMM	Created Date	5/31/2012 11:54 AM
Updated By	Mikan, Leslie, LLMM	Updated Date	5/31/2012 11:54 AM
Billing Form	837P	Transmit Date	
Order	Primary	Ignore Warnings	No
Service Month/Year	4/1/2012	HIPAA Processing Set	
		837 File Status	
		Transmission Message	

1

Errors List [\(Export\)](#)

Batch #	Level	Message	Created	Claim #	Item #
302	error	There is no Agency Payor Plan for agency Administrative Agency and plan MMIS-WBC.	2/19/2013		

1 Batch errors will appear in the **Error List** screen. The **Message** displays the error description. Each error needs correction. The batch will re-process automatically. After all errors are successfully corrected, the [837 download](#) link will appear. The next screen walks through the most common errors with an explanation of how to correct each of the errors.

Provider Claim Batch Profile – Common errors and corrections

Provider Claim Batch Profile					
Batch #	482	Charge Amount	\$698.50		
Batch For	PHTECH	Status	Billed		
Created By	Mikan, Leslie, LLMM	Created Date	3/14/2013 3:48 PM		
Updated By	Mikan, Leslie, LLMM	Updated Date	3/14/2013 3:50 PM		
Billing Form	837P	Transmit Date	3/14/2013 3:48 PM		
Order	Primary	Ignore Warnings	No		
Service Month/Year	3/1/2013				
HIPAA Processing Set					
837 File Status		837 Generation Errors - Auto Retry			
Transmission Message					

Errors List <i>(Export)</i>					
Batch #	Level	Message	Created	Claim #	Item #
1 482	error	Submitter contact phone must be 10 numeric characters.	3/14/2013	723	770
2 482	error	Address is missing for billing provider SA/MH Demo Agency.	3/14/2013	723	770
3 482	error	Missing primary qualifier or number for rendering provider Billing, OWITS.	3/14/2013	723	770

- 1 Submitter contact phone must be 10 numeric characters: Your **Agency EDI contact** must have a work phone number . Go to the *Agency>Staff List>Staff Profile>Contact Info* and enter work phone number.
- 2 Address is missing for billing provider SA/MA Demo Agency: Your Agency has to have a billing address type. Go to *Agency>Agency List>Agency Profile>Addresses/Phone* and enter an address **Address Type** = “**Agency Billing.**”
- 3 Missing primary qualifier or number for rendering provider Billing, OWITS: In the encounter, the **Rendering Provider** selected must have a valid NPI in their **Staff Profile**. The NPI can be the same as the Agency NPI. Go to *Agency>Staff List>Staff Profile* and enter a valid NPI in the field **National Provider ID**. NPI# is required for all staff members selected as rendering providers.

Provider Claim Batch Profile – Common errors and corrections

Once each error is corrected, the batch file will automatically re-process. Go to Agency>Billing>Claim Batch List. In the **Provider Claim Batch List** screen, filter your search by the status of “Batch Processing Error” click [Go](#). In the Claim Batch List screen find the batch# and in the Actions column click on Profile. **1** In the example below, notice the third error is gone. The agency billing address issue was corrected. **2** This example displays the error list after Missing primary qualifier is corrected. **3** After the last error, Submitter contact phone number is corrected, the Error List will be blank. **4** Scroll to the bottom of the screen, in the [Administrative Actions](#) list the [Download 837](#) link will display. Download 837 process was explained in an earlier page.

1 **Errors List** [\(Export\)](#)

Batch #	Level	Message	Created	Claim #	Item #
482	error	Submitter contact phone must be 10 numeric characters.	3/14/2013	723	770
482	error	Missing primary qualifier or number for rendering provider Billing, OWITS.	3/14/2013	723	770

2 **Errors List** [\(Export\)](#)

Batch #	Level	Message	Created	Claim #	Item #
482	error	Submitter contact phone must be 10 numeric characters.	3/14/2013	723	770

3 **Errors List** [\(Export\)](#)

Batch #	Level	Message	Created	Claim #	Item #

4 **Administrative Actions**

[Download 837](#)

Finish

Claim Item Adjustment – Reject(BackOut)

To reject or back out a claim.

- 1 In the Administrative Actions area, click on [Reject \(BackOut\)](#).

Profile for Claim Item #950 for bar, granola

ENC ID: 850	Delivered Service: H0001/HF
Program: Woodburn Program	Service Start: 6/6/2013 12:00 AM
Diagnoses: 303.00 / /	Service End: 6/6/2013 12:00 AM
Pregnant: No	Duration:
Status: Released	# Sessions/Units: 1
	Rendering Staff: Mikan, Leslie, LLMM

Service Fee

Billing Units X Rate / Unit =

Group Enrollment

Payor Billing Service

Service Location

Unit Desc

Voucher Authorized Remaining

Cost Center

Billing Note

Encounter Post Date

Created Date

Administrative Actions

[Awaiting Review](#) [Hold](#) [Reject \(Back Out\)](#)

1

Claim Item Adjustment – Reject(BackOut)

After selecting Reject(Back Out) from the claim item profile Administrative Actions, the following window will open.

This action will cause this service to be rejected back to the clinician. If you are sure that you want to do this, then enter a reason and click confirm; otherwise click cancel.

1 Rejection Reason

Type the reason you are rejecting claim in this box.

Cancel Confirm

1 In the Rejection Reason text box, type your reason for Rejecting Claim. Once complete, click Confirm.

2 This returns you to the Claim Item List screen. To find your rejected item go to Agency>Billing>Encounter List. In the Encounter Search change the Status field to “Rejected” then click GO. All Rejected items will display.

3 In the Encounter List, click on the Details to view reason the encounter was rejected. Then in the [Actions](#) column, click on [Profile](#). This will open the Encounter where the correction can be made. Then click SAVE and [Release to Billing](#).

Encounter Search

Enc ID Rendering Staff Supervising Staff

First Name Last Name

Program SSN Procedure Code

2 Status Service Start Facility

Balance Payor Plan

Clear Go

Encounter List (Export)

Enc ID	Client Name	Svc Start	Status	Duration	Procedure	Rend. Staff	Program Name	Balance	Actions
850	bar, granola	6/6/2013	Rejected (Details) 3		H0001	Mikan, Leslie, LLMM	Woodburn Program	\$0.00	Profile

Claim Adjudication/Payments

- Claim Adjudication - Upload 835
 - EOB Transaction
- Payment List
 - Plan Payments
 - Applying Payment
 - Add EOB
 - Bill Another Payor
 - Encounter Billing History
 - Claim Items

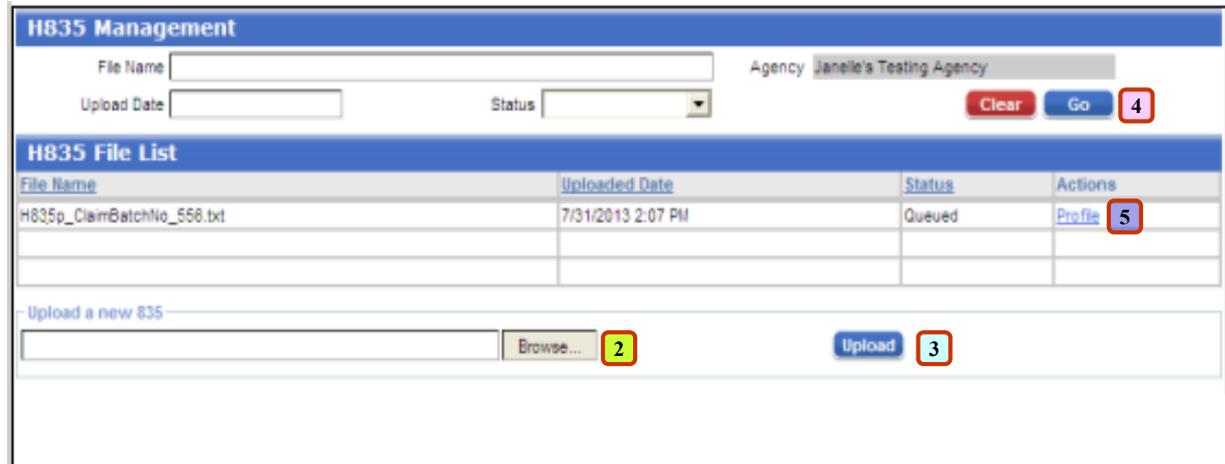
Claim Adjudication- 835 file upload

When the clearing house or insurance company has processed the claims, you will receive the 835 files and a summary report.

- 1 From the Billing module, click on H835 Management.
- 2 To load 835 files, click on Browse, and browse to the location of the 835 file to load.
- 3 Click on Upload to load your selected file. You must upload them one file at a time.

From the 835 Management option, you can review the status of uploaded files

- 4 Click on the GO button to display all uploaded 835 files.
- 5 To view the status and results of the 835 file, click on Profile from the Actions column. (See next page for example).



Claim Adjudication- 835 file upload

continued

1 From the prior page, the H835 profile is displayed. This will show you the status, payments and any errors that occur.

1 H835 Profile

File Name	835_104698_931211733_93-1164505_20130422101605.txt	Uploaded By	Mikan, Leslie, OIS
Agency	Administrative Agency	Upload Date	6/3/2013 3:55 PM
Status	Processed	Process Start Date	6/3/2013 4:49 PM
HIPAA Processing Set	Generic 837/835 (5010)	Process End Date	6/3/2013 4:52 PM

[Finish](#)

Payments

Payment #	Agency	Plan	Amount	Reference #
105167	Administrative Agency for Wellness	MMIS-	\$0.00	0

Errors(Export)

Code	Message

Administrative Actions

[Download 835](#)

Claim Adjudication- 835 file Explanation of Benefits (EOB)

Once the 835 file has been loaded and claims adjudicated, the claims can then be adjusted. Claims are locked down until the adjudication process has been completed.

- 1 To view the adjudicated claims, navigate to: *Agency>Billing>EOB Transaction List*. Payment application and adjustments will display.
- 2 This list can be exported by clicking on the **(Export)** link in the List. This feature is useful if you wish to create a report or add to an existing billing system.

1 EOB Transaction Search

EOB Transaction Type	<input type="text" value="Payment"/>	Enc #	<input type="text"/>
First Name	<input type="text"/>	Last Name	<input type="text"/>
Payment #	<input type="text"/>	Payor Name	<input type="text"/>
		<input type="button" value="Clear"/>	<input type="button" value="Go"/>

EOB Transaction List (Export) 2									
Enc #	Client Name	Svc Date	Transaction Type	Adjustment Reason	App Amt	App Date	Pmt #	Payor Name	Actions
163790	Real,Girl	4/10/2012	Payment		\$54.57	3/12/2013	104545	MMIS	
163791	Real,Girl	4/11/2012	Payment		\$95.43	3/12/2013	104545	MMIS	
153844	Real,Girl	4/13/2012	Payment		\$14.39	3/12/2013	104545	MMIS	
163797	Real,Girl	4/16/2012	Payment		\$98.11	3/12/2013	104545	MMIS	
163802	Real,Girl	4/18/2012	Payment		\$67.56	3/12/2013	104545	MMIS	
163803	Real,Girl	4/19/2012	Payment		\$54.57	3/12/2013	104545	MMIS	
163804	Real,Girl	4/23/2012	Payment		\$95.43	3/12/2013	104545	MMIS	
163805	Real,Girl	4/24/2012	Payment		\$14.39	3/12/2013	104545	MMIS	
163807	Real,Girl	4/25/2012	Payment		\$98.11	3/12/2013	104545	MMIS	
163781	Real,Girl	4/29/2012	Payment		\$67.56	3/12/2013	104545	MMIS	
163810	Real,Girl	4/30/2012	Payment		\$54.57	3/12/2013	104545	MMIS	
151426	Real,Girl	4/3/2012	Payment		\$95.43	3/12/2013	104545	MMIS	
151424	Real,Girl	4/7/2012	Payment		\$14.39	3/12/2013	104545	MMIS	
166805	Real,Girl	4/16/2012	Payment		\$98.11	3/12/2013	104545	MMIS	

Payment List – Plan Payments

To apply payments manually to claims/encounters, you will use the **Payment List** screen.

Navigate to *Agency>Billing>Payment List*. In the **Payment List** there are 3 options for applying payments.

Payment Search

Payor Plan	<input type="text"/>	First Name	<input type="text"/>	Last Name	<input type="text"/>
Pmt #	<input type="text"/>	Posted Date	<input type="text"/>	Reference	<input type="text"/>
Payment Amount	<input type="text"/>	Unapplied Amount	<input type="text"/>		
Contractor	<input type="text"/>				

Payment List *(Export)*

[Add Contract Payment](#) [Add Client Payment](#) [Add Plan Payment](#)

<u>Pmt #</u>	<u>Payor Name</u>	<u>Posted</u>	<u>Payment Amount</u>	<u>Unapplied Amount</u> 1	<u>Intended F</u> 2	<u>Created By</u> 3	<u>Actions</u>

Payment List options:

- 1** Add Contract Payment : (this feature is only used by the state contracting department).
- 2** Add Client Payment: This feature is used for adding a payment to a specific client, regardless of group enrollment.
- 3** Add Plan Payment: This feature is used to add a payment to a specific benefit plan regardless of client.

Plan Payments

In the **Payment Profile** window:

- 1 Select the **Plan Name** from the drop down box
- 2 Select the **Transaction Type** from the drop down box
- 3 Enter the **Receipt Date**
- 4 Enter the **Payment Amount**
- 5 Select the **Intended For** from the drop down box (field is not required)
- 6 Click **Save**
- 7 Select **Apply Payment** in the **Administrative Actions**

The screenshot shows the 'Payment Profile' window with the following fields and values:

- Plan Name: Blue Cross Blue Shield (highlighted with callout 1)
- Transaction Type: Payment (highlighted with callout 2)
- Receipt Date: 3/15/2013 (highlighted with callout 3)
- Payment Amount: 15.00 (highlighted with callout 4)
- Intended For: On Account (highlighted with callout 5)
- Administrative Actions: [Apply Payment](#) (highlighted with callout 7)
- Buttons: Cancel, Save (highlighted with callout 6), Finish

Lists available plans.

A list of available plans with 'Blue Cross Blue Shield' selected (highlighted with callout 1):

- Blue Cross Blue Shield
- OHP Test Plan
- PHTECH

Transaction Type

A list of transaction types with 'Payment' selected (highlighted with callout 2):

- Payment
- Refund
- Adjustment

Plan Payments - Applying Payment

In the **Payment Application Claim list** **Actions** Column, **2** click in the appropriate check box and then click on [Select](#) for that claim #. The Payment Application Claim Profile screen will appear.

Payment Application Claim Search

Payment # Unapplied Amount Order of Benefits

First Name Last Name Claim #

Member # Plan Name

Claim Balance Claim Charge

Payment Application Claim List

1 [Paid in Full](#)

<input type="checkbox"/>	Claim #	Client Name	Member #	Charge	Claim Balance	DOS	Order of Benefits	Actions
2 <input checked="" type="checkbox"/>	724	Smith, Jane	99-3698	\$50.00	\$50.00	2013/03/15-2013/03/15	Primary	Select
<input type="checkbox"/>	725	Smith, Jane	99-3698	\$100.00	\$100.00	2012/08/04-2012/08/04	Primary	Select
<input type="checkbox"/>								

1 The **Paid in Full** feature is used only if you wish to pay the entire claim. For this feature: **2** place a check mark next to the claim you wish to pay in full and click on **Paid in Full**.

Plan Payments – Applying Payment

continued

- 1 The selected claim will appear in the **Payment Application Claim Item List for Claim # ()** screen. In the **Actions** column, click on [Select](#).

Payment Application Claim Profile					
Payment #: 377	Plan Name: Blue Cross Blue Shield	Claim Charge Amt: \$50.00			
Claim #: 727	Client Name: Smith, Jane	Claim Balance: \$50.00			
Member #: 99-3698	Order of Benefits: Primary	Unapplied Amt: \$15.00			
Payment Application Claim Item List for Claim # 727					Bill Another Payor 2
Item #	Service	Service Date	Charge	Enc Balance	Actions
773	H0005/HF	3/10/2013	\$50.00	\$50.00	Select Billing History
					1 3

[Finish](#)

- 2 The ***Bill Another Payor*** Feature will be covered later in this document.

- 3 The [Billing History](#) can be viewed at any time by clicking on the [Billing History](#) link.

Plan Payments – Add EOB

In the **1** **EOB Transactions for Item # ()** box, click on **2** **Add EOB Transaction**. **3** This will change the payment options from read only to editable fields.

Payment Application Claim Profile					
Payment #: 377	Plan Name: Blue Cross Blue Shield	Claim Charge Amt: \$50.00			
Claim #: 727	Client Name: Smith, Jane	Claim Balance: \$50.00			
Member #: 99-3698	Order of Benefits: Primary	Unapplied Amt: \$15.00			
Payment Application Claim Item List for Claim # 727					Bill Another Payor
Item #	Service	Service Date	Charge	Enc Balance	Actions
773	H0005/HF	3/10/2013	\$50.00	\$50.00	Select Billing History

1 **EOB Transactions for Item # 773** **2** **Add EOB Transaction**

Amount	Type	Reason	Comment	Date	Actions

3 Amount Type

Reason

Comment

Finish

Plan Payments – Add EOB

continued

- 1 Fill in the Amount,
- 2 The **Type** field selection should always be “**Payment**”. All other selections are adjustments (*covered later*).
- 3 Selecting the **Type** of ” **Payment**”, changes the rule of the **Reason** field to no longer required. The **Reason** field is only required if the **Type** is an adjustment type.
- 4 Enter the **Procedure Code** (Procedure Modifier is not required) and **5 Paid Unit Count**.
- 6 Click **Save**.

The screenshot displays the 'Plan Payments – Add EOB' form. It includes several input fields and a dropdown menu. A red box highlights the 'Type' dropdown menu, which is open and shows the following options: Payment, Patient Responsibility, Contractual Obligations, Other adjustments, Payor Initiated Reductions, Correction and Reversals, and Remark. A red box with the number '2' points to this dropdown. Other fields are highlighted with yellow boxes and numbered callouts: '1' points to the 'Amount' field containing '\$15.00'; '3' points to the 'Reason' field; '4' points to the 'Procedure Code' field containing 'H0005'; '5' points to the 'Paid Unit Count' field containing '1'; and '6' points to the 'Save' button. The 'Type' field is also highlighted with a yellow box and contains 'Payment'. The 'Comment' field is empty. At the bottom right, there are three buttons: 'Cancel' (red), 'Save' (green), and 'Finish' (blue).

Plan Payments – Add EOB

continued

- 1 In the Payment Application Claim Item List for Claim # click Select to review payment, or Billing History to review all payment history for plan. Other Options are:
- 2 Delete or Edit payment
- 3 Bill Another Payor
- 4 Add EOB Transaction (payment)
- 5 If billing is complete for this transaction, click **Finish**

Payment Application Claim Profile

Payment #: 377	Plan Name: Blue Cross Blue Shield	Claim Charge Amt: \$50.00
Claim #: 727	Client Name: Smith, Jane	Claim Balance: \$35.00
Member #: 99-3698	Order of Benefits: Primary	Unapplied Amt: \$0.00

Payment Application Claim Item List for Claim # 727 3 [Bill Another Payor](#)

Item #	Service	Service Date	Charge	Enc Balance	Actions 1
773	H0005/HF	3/10/2013	\$50.00	\$35.00	Select Billing History

EOB Transactions for Item # 773 4 [Add EOB Transaction](#)

Amount	Type	Reason	Comment	Date	Actions 2
\$15.00	Payment			3/15/2013	Delete Edit

Amount Type

Reason

Comment

5 **Finish**

Plan Payments – Bill Another Payor

Bill Another Payor feature allows the user to bill a second payor plan for the encounter and service currently being billed.

- 1 Order of Benefits selects the order of the payor plan. In this case it is Secondary
- 2 The Group Enrollment populates from the Client Profile associated with the Encounter. Select plan to bill.

Bill Another Payor

1 Order of Benefits

Group Enrollment

Initial Status

Tertiary

> 3

Encounters

Enc #	Units	Charge	Service	Service Date	Encounter Balance	Actions
1222	1.00	\$145.00	H0001/HF-Alcohol and/or Drug Assessment	1/24/2013	\$123.00	Edit

Bill Another Payor

Order of Benefits

2 Group Enrollment

Initial Status

General [MMIS]

GWH #1 [1001 Great West Healthcare]

GWH #1 [Office Ally]

GWH #1 [Office Ally]

Encounters

Enc #	Units	Ch	Service	Service Date	Encounter Balance	Actions
1222	1.00	\$145.00	H0001/HF-Alcohol and/or Drug Assessment	1/24/2013	\$123.00	Edit

Plan Payments – Bill Another Payor

continued

- 1 The **Order of Benefits** is now read-only.
- 2 The **Group Enrollment** displays the selection made.
- 3 The **Initial Status** defaults to “Released”. Other options are “Awaiting Review” and “Hold.”
- 4 These selections are added to the encounter record.
- 5 In the **Encounter List/Actions** column, select [Billing History](#) if you want to review.

Bill Another Payor

1 Order of Benefits

2 Group Enrollment

3 Initial Status

3

Awaiting Review

Hold

Released

Encounters

Enc #	Units	Charge	Service	Service Date	Encounter Balance	Actions
1222	1.00	\$145.00	H0001/HF-Alcohol and/or Drug Assessment	1/24/2013	\$93.00	Edit

Encounter Search

4 Enc ID

First Name

Program

Status

Balance

Rendering Staff

Last Name

SSN

Service Start

Payor Plan

Supervising Staff

Procedure Code

Facility

Encounter List *(Export)*

Enc ID	Client Name	Svc Start	Status	Duration	Procedure	Rend. Staff	Program Name	Balance	Actions
4 1222	bar, granola	1/24/2013	Released		H0001	Mikan, Leslie, LLMM	Mental Health Test	\$123.00	Profile Billing History
									5

Plan Payments – Encounter Billing History

Below is the view of the Billing History for the selected Encounter.

Billing History for Encounter # 1330 --- Smith, Jane(F759001UH006110)							
Service H0005/HF - A&D srvs; group counseling by clinician				Encounter Balance: \$85.00			
Service Start 8/4/2012 12:00 AM				Duration:			
Service End 8/4/2012 12:00 AM				# of Sessions 2			
Program Name SA Demo Facility/TEDS-DUII : 8/3/2012 -				Rendering Staff Mikan, Leslie, LLMM			
Claim Item List							
Id #	Plan Name	Order of Benefits	Charge	Claim Item Status	Created Date	Created By	
772	Blue Cross Blue Shield	Primary	\$100.00	Batched	3/15/2013	Mikan, Leslie	
774	PHTECH	Secondary	\$100.00	Released	3/15/2013	Mikan, Leslie	
Billing Transaction List							
Id #	Type/Source	Charge	Credit	Adjustment Reason	Comment	Created Date	Created By
1298	Charge	\$100.00	\$0.00			3/15/2013	Mikan, Leslie
1300	Payment Application - Blue Cross Blue Shield (Pymt # 376)	\$0.00	\$15.00		client paid in cash	3/15/2013	Mikan, Leslie
EOB Transaction List							
Id #	Plan Name Source	Type	Amount	Adjustment Reason	Comments	Created Date	Created By
580	Blue Cross Blue Shield (Pymt # 376)	Payment	\$15.00		client paid in cash	3/15/2013	Mikan, Leslie

Plan Payments – Claim Items

The **Bill Another Payor** feature creates a claim item with the status of “Released” for the selected Procedure code. The claim is ready to be batched. You would follow the steps for batching as explained earlier in this manual.

Claim Item Search

Plan <input type="text"/>	Group Enrollment <input type="text"/>	ENC ID <input type="text" value="1222"/>
Client First Name <input type="text"/>	Client Last Name <input type="text"/>	Charge <input type="text"/>
Subscriber/Resp Party First Name <input type="text"/>	S/R Party Last Name <input type="text"/>	Service <input type="text"/>
Subscriber/Resp Party Account # <input type="text"/>	Rendering Staff <input type="text"/>	Service Date <input type="text"/>
Voucher # <input type="text"/>		
Item Status <input type="text"/>	Facility <input type="text"/>	

[Create Batches](#)

Claim Item List *(Export)*

Item #	Client Name	Service Date	Service	Duration	Status	Release Date	Charge	Actions
697	bar, granola	1/24/2013	H0001/HF		Batched	1/24/2013	\$145.00	Profile
779	bar, granola	1/24/2013	H0001/HF		Released	1/24/2013	\$145.00	Profile

Billing Module Conclusion

The billing documentation will be updated as features change and are added. Please feel free to send your review of all user guides and documents.

Notification will be sent out promptly with changes.

For questions regarding billing, please contact FEI's OWITS Support team.

Email: OwitsSupport@witsweb.org

Phone: 443-546-9219